"PA"

Date 3/20/17

BRADEN SCALE

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction/Shear	17–23 Low Risk Less than or Equal to 16 High Risk and Initiate Prevention Protocol
1. Completely Limited 2. Very Impaired 3. Slightly Limited 4. No Limitation	1. Constantly 2. Moist 3. Occasionally 4. Rarely	1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently	1. Completely Immobile 2. Very Limited 3. Slightly Limited 4. No Limitations	1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent	1. Mod/Max turn Assist 2. Minimum Assist 3. No Apparent Problem	Total Score: / Initial 0700 ___ / ___ 1900 23 / [initial]

FALL RISK

Morse Fall Scale	Numeric Values	0700 Score	1900 Score
History of Falling	No=0 Yes=25		—
Secondary Diagnosis (see list)	No=0 Yes=15		15
Ambulatory Aids			
None/Bedrest/Nurse Assist	0		
Crutches/Cane/Walker	15		
Uses Furniture to Support	30		
IV Access	No=0 Yes=20		
Gait/Balance			
Normal/Bedrest/Wheelchair	0		
Weak	10		
Impaired	20		
Mental Status			
Oriented to Own Ability	0		
Overestimates or Forgets Limitations	15		
	Total Score		15
	Initials		[initial]

Secondary Diagnosis Which Includes:
- Dizzy
- Orthostatic Hypotension
- Agitation/Delirium
- Frequent Toileting/Incontinence
- Impaired Mobility/Vision/Hearing

Medications:
- Diuretics
- Psychotropics
- Antihistamines
- Narcotics
- Anticoagulants
- Anticonvulsants

Morse Fall Scale Score:
0-44 LOW RISK (Hourly Rounds)
45-Higher HIGH RISK (Implement Falling Star Program)

0700	1900
☐ No Needs Identified	☒ No Needs Identified
☐ Falling Star Program	☐ Falling Star Program

	Initial	Date	Time
RN Signature			
RN Signature [signature]	[initial]	3/20/17	2254

DATE	TIME	NOTES SHOULD BE SIGNED, DATED, AND TIMED
3/20/17	2254	Ambulatory to unit from ER c̄ [illegible] + ER staff. Dx MDD severe c̄ suicidal behavior for Dr Haiderzad. [signature]
3-21-17	0015	B – M.H. [illegible] & father/mom cooperative c̄ admission process. All documents/forms explained to & signed. Copy of guardianship placed in chart. — [signature]

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 3 of 4

Patient Label

M.H.
Acct#1750544 MR#0000133244 0270-2 17
HAIDERZAD, TAL Fam:DAVIS, D L
Adm:03/20/2017 DOB: 012 F
TWIN RIVERS REGIONAL MED CTR

EXHIBIT 19

PA

DATE	TIME	NOTES SHOULD BE SIGNED, DATED, AND TIMED
3-21-17	0015	1- Unit orientation Done. Plan of care
		explained to both. Questions encouraged.
		2- Good eye contact. Soft spoken
		Responses. Denies knowing her thought
		process when she did this time
		for the last. Status: understanding
		asking questions & voicing thoughts.
		P. Will continue s/p as ordered. [illegible signature]

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 4 of 4

Patient Label

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HAIDERZAD, TAL Fam:DAVIS, D L
Adm:03/20/2017 DOB:
012 F
TWIN RIVERS REGIONAL MED CTR

'PA'

Date 3/21/2017

BRADEN SCALE

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction/Shear
1. Completely Limited 2. Very Impaired 3. Slightly Limited 4. No Limitation	1. Constantly 2. Moist 3. Occasionally 4. Rarely	1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently	1. Completely Immobile 2. Very Limited 3. Slightly Limited 4. No Limitations	1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent	1. Mod/Max turn Assist 2. Minimum Assist 3. No Apparent Problem

17–23 Low Risk Less than or Equal to 16 High Risk and Initiate Prevention Protocol

Total Score:	Initial
0700 23	MB
1900 23	CP

FALL RISK

Morse Fall Scale	Numeric Values	0700 Score	1900 Score
History of Falling	No=0 Yes=25	0	0
Secondary Diagnosis (see list)	No=0 Yes=15	0	0
Ambulatory Aids			
None/Bedrest/Nurse Assist	0	0	0
Crutches/Cane/Walker	15		
Uses Furniture to Support	30		
IV Access	No=0 Yes=20	0	0
Gait/Balance			
Normal/Bedrest/Wheelchair	0	0	0
Weak	10		
Impaired	20		
Mental Status			
Oriented to Own Ability	0	0	0
Overestimates or Forgets Limitations	15		
	Total Score	0	0
	Initials	MB	CP

Secondary Diagnosis Which Includes:

- Dizzy
- Orthostatic Hypotension
- Agitation/Delirium
- Frequent Toilating/Incontinence
- Impaired Mobility/Vision/Hearing

Medications:

- Diuretics
- Psychotropics
- Antihistamines
- Narcotics
- Anticoagulants
- Anticonvulsants

Morse Fall Scale Score:
0-44 LOW RISK (Hourly Rounds)
45-Higher HIGH RISK (Implement Falling Star Program)

0700	1900
☑ No Needs Identified	☑ No Needs Identified
☐ Falling Star Program	☐ Falling Star Program

RN Signature: J Burks, RN — Initial MB Date 3/21/17 Time 1045

RN Signature: Gillian Carter, LPN / T Rickard RN 2/17 2154 — Initial CP Date 3/21/17 Time 1900

DATE	TIME	NOTES SHOULD BE SIGNED, DATED, AND TIMED
3/21/17	1045	Pt awake, A/O x3, participates appropriately & Assessment. Calm, Cooperative, Appropriate eye contact. Nurse assessed SI/HI, depression, Anxiety & hallucinations. M.H. denies thoughts of harming Self or others. She denies depression/Anxiety. She reports thoughts of self harm, non suicidal, due to dads head being set back. Nurse encouraged M.H. to participate in treatment, groups, & activities. M.H. agrees to (cont)

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 3 of 4

Patient Label

M.H.
Acct#1750544 MR#0000133244 0270-217
HAIDERZAD, TAL Fam:DAVIS, D L
Adm:03/20/2017 DOB:
TWIN RIVERS REGIONAL MED CTR
012 F

PA

DATE	TIME	NOTES SHOULD BE SIGNED. DATED, AND TIMED
3/21/17	1045	notify staff if she has thoughts of hurting herself.
		today. Nurse encouraged M.H. to work on positive
		coping skills. M Burks, RN
3/21/17	1835	M.H. interacted well with staff + peers, she
		participated in all groups + activities. No needs
		identified. Report given to oncoming staff for continued
		care. M Burks, RN
3/21/17	1930	B: Patient is calm and cooperative during
		assessment. Patient interacts well c̄ peers
		while in group room
		I: To assess patient for SI/HI, thoughts of
		harming herself or others, to have patient
		rate depression and anxiety levels, and to
		encourage patient to use appropriate
		coping skills
		R: Patient denies any SI/HI, denies thoughts
		of harming herself or others ~~to rate~~ patient
		rates both depression and anxiety at 0/10.
		Patient reports that it helps her to talk to
		her foster mom and real mom when she
		is upset.
		P: To maintain a safe environment and to
		encourage patient to participate in all groups
		and treatment [illegible]
3/21/17	2452	M.H. has been quiet + withdrawn, but
		she smiles c̄ staff + admits that she feels
		"ok". Cooperative c̄ staff. Not sociable
		c̄ peers or staff. [illegible] RN

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 4 of 4

Patient Label

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HAIDERZAD, TAL Fam:DAVIS, D L
Adm:03/20/2017 DOB: 012 F
TWIN RIVERS REGIONAL MED CTR

"PA"

Date 3/22/2017

BRADEN SCALE

Sensory Perception	Moisture	Activity	Mobility	Nutrition	Friction/Shear	17–23 Low Risk Less than or Equal to 16 High Risk and Initiate Prevention Protocol	
1. Completely Limited 2. Very Impaired 3. Slightly Limited 4. No Limitation	1. Constantly 2. Moist 3. Occasionally 4. Rarely	1. Bedfast 2. Chairfast 3. Walks Occasionally 4. Walks Frequently	1. Completely Immobile 2. Very Limited 3. Slightly Limited 4. No Limitations	1. Very Poor 2. Probably Inadequate 3. Adequate 4. Excellent	1. Mod/Max turn Assist 2. Minimum Assist 3. No Apparent Problem	Total Score:	Initial
						0700 23	[illegible]
						1900 23	DS

FALL RISK

Morse Fall Scale	Numeric Values	0700 Score	1900 Score
History of Falling	No=0 Yes=25	0	0
Secondary Diagnosis (see list)	No=0 Yes=15	0	15
Ambulatory Aids			
None/Bedrest/Nurse Assist	0	0	0
Crutches/Cane/Walker	15		
Uses Furniture to Support	30		
IV Access	No=0 Yes=20	0	0
Gait/Balance			
Normal/Bedrest/Wheelchair	0	0	0
Weak	10		
Impaired	20		
Mental Status			
Oriented to Own Ability	0	0	0
Overestimates or Forgets Limitations	15		
Total Score		0	15
Initials		[illegible]	DS

Secondary Diagnosis Which Includes:

- Dizzy
- Orthostatic Hypotension
- Agitation/Delirium
- Frequent Toileting/Incontinence
- Impaired Mobility/Vision/Hearing

Medications:

- Diuretics
- Psychotropics
- Antihistamines
- Narcotics
- Anticoagulants
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Morse Fall Scale Score:
0-44 LOW RISK (Hourly Rounds)
45-Higher HIGH RISK (Implement Falling Star Program)

0700	1900
☑ No Needs Identified	☑ No Needs Identified
☐ Falling Star Program	☐ Falling Star Program

RN Signature	Initial	Date	Time
[signature] RN	[illegible]	3/22/17	0800
Darnell Shipley	DS	3-22-17	1930

DATE	TIME	NOTES SHOULD BE SIGNED, DATED, AND TIMED
3/22/2017	0800	M.H. maintains eye contact, slept well, monotoned speech, answered questions appropriately. Assessed pt 1:1 for privacy, allowed pt time to discuss current feelings, thoughts or fears.
		M.H. Reports slept well š interruption

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 3 of 4

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PA

DATE	TIME	NOTES SHOULD BE SIGNED, DATED, AND TIMED
3/22/2017	0800	Denies feelings of anxiety or depression "I have a real good relationship with my foster mom, we just clicked, and her and my real mother gets along really good." Pt reports Ø feelings of self harm Ø thoughts of suicide. Denies questions or concerns @ this time. Encouraged pt to verbalize & acquire strategies as well as appropriate ways to get message across believes no one would listen. — GCeappke
3/22/17	1943	M.H. pleasant / cooperative, quiet, answers questions appropriately Ø needs identified @ this time. Will continue to monitor for safety — GCeappke
3/22/17	1845	M.H. Spoke c̄ Bio Mom on phone Speaker phone c̄ this nurse @ patient side — GCeappke
3-22-17	1930	Patient is alert and oriented X4 appropriate eye
	B	contact flat affect. Patient is calm and cooperative with staff. Limited interaction with peers
	I	Provided patient privacy, encouraged self-disclosure
	R	Patient denies suicidal or homicidal ideations. She identifies "Dad's trial" as the cause of her depression. Patient states the trial has been ongoing for the past three years and has recently been set back again. Patient denies feelings of depression or anxiety. No problems reported with medications, patients or staff.
	P	Continue to provide a safe environment and monitor per protocol — Darnell Shipley RN
3/23/17	0130	M.H. Participated during group activities. Limited interaction with peers. Patient resting quietly with eyes closed. Respirations are regular, even and unlabored. No distress noted. Will monitor per protocol — Darnell Shipley RN
3/23/17	0600	Patient continues to sleep quietly. No distress noted. Will monitor per protocol — Darnell Shipley RN

Behavioral Health Services
24-Hour Flow Sheet
1488-TWR-190937HMS 02/15 (Rev. 12/15) Page 4 of 4

Patient Label

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HAIDERZAD, TAL Fam:DAVIS, D L
Adm:03/20/2017 DOB: 012 F
TWIN RIVERS REGIONAL MED CTR